SECTION 2: SELF-MANAGEMENT EDUCATION

Concern	Care/Test	Frequency
Self-Management Education	♦ Refer to diabetes educator, preferably a certified diabetes educator (CDE); curriculum to include the ten key areas of the national standards for diabetes self-management education	At diagnosis, then every 6 – 12 months or more as needed

The primary goal of diabetes self-management education (DSME) is to provide knowledge and skill training, facilitate problem solving, help people identify barriers to change, and nurture the development of coping skills with the goal of achieving effective self-management and behavior change. Self-management education encourages goal setting (short- and long-term) and emphasizes the need for realistic and obtainable goals based on the person's readiness to change. These goals are negotiated jointly with the person, family members, the primary care provider, and the diabetes team. The goals and interventions are evaluated regularly and revised to achieve desired health outcomes. Diabetes educators assess the many factors influencing the process and outcomes of self-management education and provide guidance and information specifically tailored to the individual person.

One of the goals of Healthy People 2010 includes increasing the percentage of individuals in the United States who receive formal diabetes education to 60% (from the current 40%). It is currently estimated that 50-80% of people with diabetes lack the knowledge and skills needed to adequately self-manage their diabetes. It is also estimated that less than half of people with Type 2 diabetes achieve an A1c of < 7.0%. Participating in a self-management educational program, regardless of the educational technique used, can help people with diabetes to lower their A1c levels by approximately two percent. Given what is known about the importance of self-management to the health of those with diabetes, medical treatment for people with diabetes that does not include self-management education is unacceptable.

Over the past several years, the efficacy of diabetes education has been reviewed, giving way to the evolution of new techniques. Self-management education, sometimes referred to as "patient empowerment," is one of these techniques. Traditionally, patient education has been aimed at increasing the person's adherence to a treatment plan developed by a health care provider. While still used by many health care providers, self-management education is gradually replacing this didactic strategy.

National Standards for Diabetes Self-Management Education Programs

The American Association of Diabetes Educators (AADE) has established specific standards for DSME. These standards are designed to define quality DSME that can be implemented in diverse settings and facilitate improvement in the health care outcomes for people with diabetes. There are ten evidence-based standards that address the structure, process, and outcomes of quality diabetes education programs. A complete listing of those standards is available on the AADE web site: http://www.diabeteseducator.org/AboutAADE/99ScopeStandards.html.

According to the ten evidence-based standards, each diabetes program must include a written curriculum with criteria for successful learning outcomes. The curriculum includes an educational needs assessment, a formal educational plan with implementation and evaluation of

goals (to assess the person's understanding and utilization of diabetes management skills and knowledge), and proper documentation including evidence of the education provided and goals identified.

A DSME curriculum is comprised of a survival skills program, followed by a comprehensive program. For those interested or in need of additional skill development, an intensive management program is available. Each of these components is outlined below:

➔ ***Survival Skills Self-Management Program***

Ideally, all people with diabetes would be able to complete a comprehensive program. If this is not possible at the time of diagnosis, there are several skills that are essential for the safety of the person with diabetes in the weeks following initial diagnosis. In this critical time, treatment and lifestyle changes may lower blood glucose considerably. People with diabetes will need to learn the following survival skills immediately after diagnosis:

- Self-monitoring of blood glucose levels (more information on self-monitoring of blood glucose is located in Section 4: Glycemic Control)
- Medication action and dosing
- Symptoms and treatment of hypoglycemia and hyperglycemia
- Basic food planning to promote glucose stabilization, taking into account the action of medication(s)
- Who to call in a diabetes emergency

➔ ***Comprehensive Self-Management Program***

A comprehensive self-management program is an interactive educational process completed as an inpatient or an outpatient, either individually or in a group format. A successful diabetes self-management program must include an assessment of individual needs to determine the amount and type of education. The educational assessment includes the following components:

- Health history
- Medical history
- Previous and current use of medications
- Nutrition history
- Current mental health status
- Family and social supports
- Previous diabetes education, actual knowledge, and skills
- Current self-management practices
- Use of health care delivery systems
- Lifestyle practices
- Physical and psychosocial factors
- Barriers to learning

The National Standards for Diabetes Self-Management Education includes ten core educational content areas. It is important for a comprehensive self-management program to include a multifaceted, educational, instructional team qualified to teach all ten of the following content areas:

- Describing the diabetes disease process and treatment options
- Incorporating appropriate nutritional management
- Incorporating physical activity into lifestyle
- Using medications (if applicable) for therapeutic effectiveness
- Monitoring blood glucose, monitoring blood and urine ketones (when appropriate), using results to improve control
- Preventing, detecting, and treating acute complications
- Preventing, detecting, and treating chronic complications
- Goal-setting to promote health, and problem-solving for daily living
- Integrating psychosocial adjustment into daily life
- Promoting preconception care, management during pregnancy, and gestational diabetes management (if applicable)

➔ ***Intensive Self-Management Program***

Intensive diabetes management is an approach or mode of treatment that has the goal of achieving euglycemia or near-normal glycemia, using all the available resources to accommodate this goal. Many people with diabetes will require additional self-management training when changing treatment plans. Individual treatment plans, such as intensive insulin therapy (continuous subcutaneous infusion pump or multiple daily injections), combined with carbohydrate counting, using insulin to carbohydrate ratios and correction doses will require specific instruction and support. A skilled diabetes health care provider and the person with diabetes should work together to obtain optimal glucose levels. This intensive education, provided by a diabetes team trained in this type of diabetes management, must be planned and designed around individual goals.

Outcomes Measurement of Diabetes Self-Management Education

Like all people providing health care, diabetes educators must also gather evidence to support their practices and modify their approaches in response to evidence. To evaluate performance, educators must not only evaluate what the diabetes education service delivers (i.e., process), but also what it is able to achieve (i.e., outcomes). For these reasons, the AADE has defined new standards of outcomes measurement for diabetes education that are practical, feasible, informative, and applicable to all DSME programs (see Table 2).

Table 2: American Association of Diabetes Educators Standards of Outcomes Measurement

1) Behavior change is the unique outcome measurement of diabetes self-management education.
2) Seven diabetes self-care behaviors can be used to measure effectiveness (see Table 3).
3) These self-care behaviors must be evaluated at baseline and at regular intervals thereafter.
4) The continuum of outcomes, including learning, behavioral, clinical, and health status, should be assessed to demonstrate the interrelationship between education and behavior change in the care of individuals with diabetes.
5) Individual patient outcomes are used to guide the intervention and improve care for that person with diabetes.

In addition to the outcome measures listed in Table 2, the AADE newly identified seven diabetes self-care behaviors integral to optimal self-management outcomes. Through the adoption of

these seven diabetes self-care behaviors, educators will be able to determine their efficacy with both individuals and populations, compare performances with established benchmarks, and measure and quantify the unique contribution that DSME plays in the overall context of diabetes care (see Table 3).

Table 3: Diabetes Self-Care Behaviors

1) Being active: physical activity (exercise)
2) Healthy eating
3) Taking medication
4) Monitoring of blood glucose
5) Problem solving, especially for blood glucose (high and low levels, and sick days)
6) Reducing risk of diabetes complications
7) Healthy coping

People facing the long-term task of making lifestyle changes benefit from assistance in setting highly specific, short-term self-care behavioral goals. Individualization is achieved by tailoring these goals and targets to the person's preferences and progress, building confidence in small steps, and implementing more intensive interventions in a stepped-care fashion. The seven self-care behavioral goals stated above can be utilized to guide people in identifying individual self-management goals. At each office visit, the health care provider's assessment of the person's progress towards their self-monitored goals and targets provides an opportunity to further enhance motivation while also customizing goals even further. Each self-care goal identified and accomplished will encourage additional positive choices, develop self-sufficiency, and assist in identifying and overcoming barriers to optimal diabetes self-care.

Literacy

At least 14% of adults in Wisconsin read at the very lowest level. Literacy Services of Wisconsin estimates that there are more than 300,000 adults with literacy needs in Wisconsin. While health literacy problems are an issue for all groups of people, people with low educational levels, linguistic or cultural barriers, and low socio-economic status clearly have even more difficulty. Many people have difficulty reading simple text or may lack the ability to understand complex information presented orally. Therefore, it is particularly important to tailor self-management education to the individual's literacy skills. Straightforward language and explanations of new or unfamiliar words is crucial. Print material should be written at a fifth grade or lower reading level. Other resources, particularly emergent technologies, such as interactive tutorials, touch screen computers, and various visual formats, can assist people in learning and absorbing new information.

Insurance Coverage

Self-management education must be available to everyone with diabetes. The American Diabetes Association (ADA) believes self-management education programs that have met accepted standards must reimburse for self-management education. Organizations that purchase health care benefits for their members or employees should insist that self-management education be included in the services provided. Managed care organizations should include these services and supplies in the basic plan available to all participants.

Referral to a Certified Diabetes Educator

Health care professionals with knowledge and expertise in diabetes management (i.e., a certified diabetes educator) provide self-management education. Diabetes educators include, but are not limited to, registered dietitians, registered nurses, physicians, pharmacists, social workers, physician assistants, and podiatrists. A certified diabetes educator (CDE) has the expertise to identify the many factors influencing the process and outcomes of self-management education and the skills to help people with diabetes, their family members, and primary care providers negotiate and develop achievable goals.

To be certified, diabetes educators must meet specific education requirements (including experience in diabetes management and counseling) and pass a qualifying exam. For more information on how to become a CDE, see the National Certification Board for Diabetes Educators web site at: http://www.ncbde.org.

Providers without designated diabetes educators may find it beneficial to refer and coordinate care with diabetes educators and health education programs found in their communities. The American Association of Diabetes Educators (AADE) has a listing of all local CDEs who are also AADE members (1-800-832-6874). There may, of course, be other local CDEs that are not members of the AADE.

Referral to an ADA Recognized Program

The goal of any self-management program should be to earn recognition status in the American Diabetes Association (ADA) Education Recognition Program (ERP). ADA Recognition identifies quality diabetes self-management services and meets criteria for Medicare reimbursement. To earn recognition status, staff must design and develop a diabetes education program, which uses and implements the National Standards for Diabetes Self-Management Education. Learn more about earning ADA recognition at: http://www.diabetes.org/for-health-professionals-and-scientists/recognition/edrecognition.jsp.

To obtain more information or a list of recognized diabetes education programs, call the American Diabetes Association at (1-800-DIABETES) or visit their web site at: http://www.diabetes.org/education/edustate2.asp.

Helpful Tools Included in This Section

- Diabetes Self-Management Behavior Goals With Graphics
- Diabetes Self-Management Behavior Goals Without Graphics
- American Diabetes Association Recognized Diabetes Education Programs in Wisconsin
- Diabetes Self-Management Education Record
- Diabetes Patient Flow Sheet/Chart Audit Tool

Additional Resources

1) Diabetes and Cardiovascular Disease Toolkit, developed by the American Diabetes Association, the American College of Cardiology, and the Preventive Cardiovascular Nurses Association. Web site located at: http://www.diabetes.org/for-health-professionals-and-scientists/CVD.jsp.

2) Keeping Well with Diabetes: an online resource for living with diabetes, developed by NovoNordisk. Web site located at: http://www.kwwd.com/kwwd/.
3) "Get the Facts on Diabetes and Your Kidneys," pamphlet developed by the National Kidney Foundation. Web site located at: http://www.kidney.org/kls/pdf/diabetespocketguide.pdf.
4) "Life with Diabetes: A Series of Teaching Outlines by the Michigan Diabetes Research and Training Center, 3rd edition." Published by the American Diabetes Association, 2004. Available to order at: http://store.diabetes.org.
5) "The Art of Empowerment: Stories and Strategies for Diabetes Educators," by Bob Anderson, EdD and Martha Funnell, MS, RN, CDE for the American Diabetes Association. Available to order at: http://store.diabetes.org.
6) The National Diabetes Education Program (NDEP) provides many and varied materials. For more information, call 1-800-438-5383 or visit the NDEP web site at: http://www.cdc.gov/diabetes/ndep/index.htm. Materials are not copyrighted.
7) "Take Charge of Your Diabetes, 3rd edition," developed by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. English version – web site located at: http://www.cdc.gov/diabetes/pubs/tcyd/index.htm. Spanish version (1997) – web site located at: http://www.cdc.gov/diabetes/pubs/controle/index.htm. Organizations may print and personalize this document adding their own organization's name.

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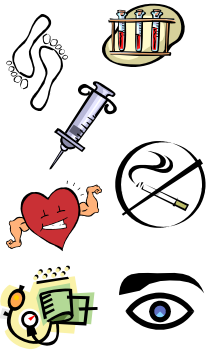
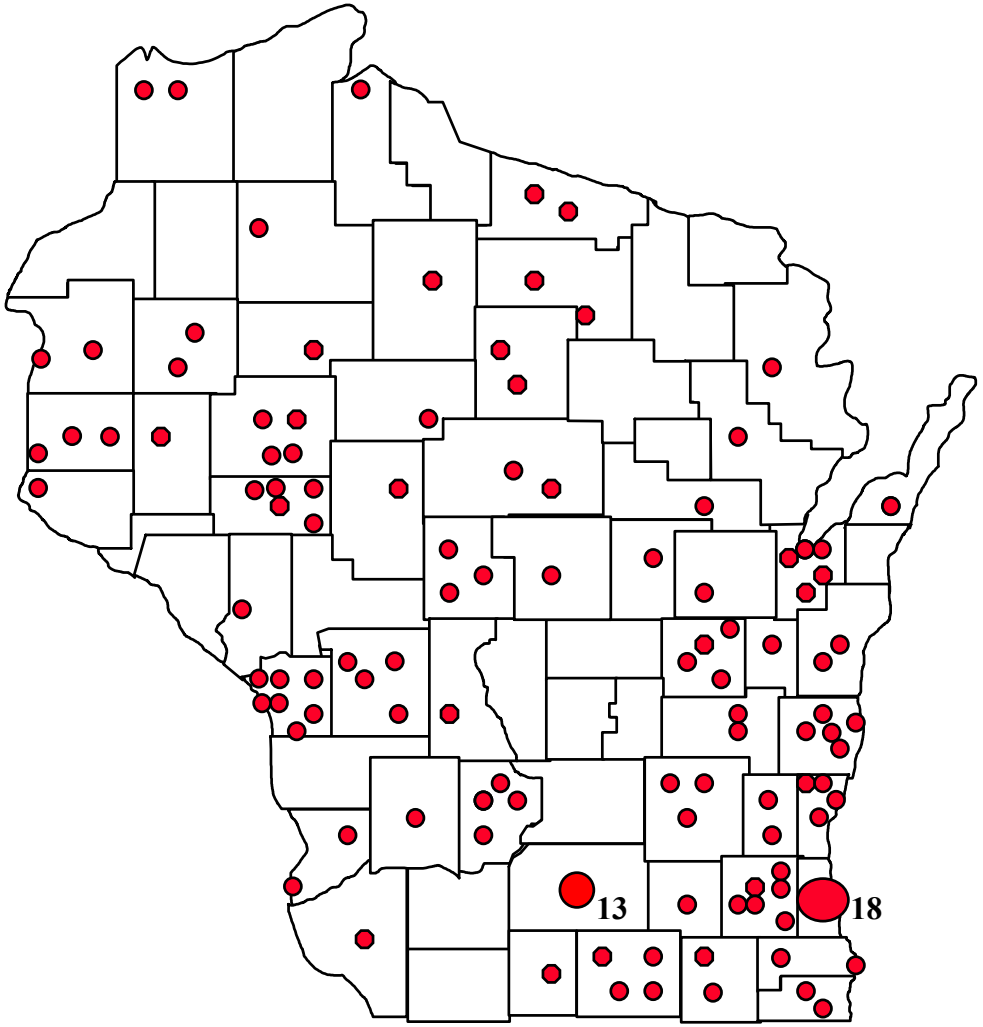
DIABETES SELF-MANAGEMENT BEHAVIOR GOALS WITH GRAPHICS

Self – Management Goals	*Choose a goal(s) that is realistic and obtainable. Use the extra space to personalize your goal(s).*	*Follow-up Date/Comment*
Goal 1: ***Be Active*** 	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Goal 2: ***Healthy Eating*** 	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Goal 3: ***Taking Medication*** 	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Goal 4: ***Monitoring*** 	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Goal 5: ***Problem Solving*** 	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Goal 6: ***Reducing Risk*** 	*I will decrease my risk of complications though these preventive care goals:* ❑ Lower or maintain my A1c at _____. ❑ Schedule a dilated eye exam ❑ Have a fasting lipid panel ❑ Get my urine checked ❑ Stop smoking ❑ See my provider every 3 to 6 months ❑ Have my blood pressure checked each visit ❑ Obtain a flu shot annually and pneumonia shot ❑ Check my own feet daily List additional goal:_____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Goal 7: ***Healthy Coping*** 	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____

DIABETES SELF-MANAGEMENT BEHAVIOR GOALS WITHOUT GRAPHICS

Self – Management Goals	*Choose a goal(s) that is realistic and obtainable. Use the extra space to personalize your goal(s).*	*Follow-up Date/Comment*
Goal 1: ***Be Active***	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Goal 2: ***Healthy Eating***	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Goal 3: ***Taking Medication***	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Goal 4: ***Monitoring***	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Goal 5: ***Problem Solving***	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Goal 6: ***Reducing Risk***	*I will decrease my risk of complications though these preventive care goals:* ❑ Lower or maintain my A1c at _____. ❑ Schedule a dilated eye exam ❑ Have a fasting lipid panel ❑ Get my urine checked ❑ Stop smoking ❑ See my provider every 3 to 6 months ❑ Have my blood pressure checked each visit ❑ Obtain a flu shot annually and pneumonia shot ❑ Check my own feet daily List additional goal:_____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Goal 7: ***Healthy Coping***	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____

AMERICAN DIABETES ASSOCIATION RECOGNIZED DIABETES EDUCATION PROGRAMS IN WISCONSIN



Wisconsin Diabetes Prevention and Control Program, August 2004

- Amery (1) – Polk County
- Appleton (1) – Outagamie County
- Arcadia (1) – Trempealeu County
- Ashland (1) – Ashland County
- Baldwin (1) – St. Croix County
- Baraboo (1) – Sauk County
- Barron (1) – Barron County
- Beaver Dam (1) – Dodge County
- Beloit (2) – Rock County
- Bloomer (1) – Chippewa County
- Brookfield (1) – Waukesha County
- Burlington (1) – Racine County
- Chilton (1) – Calumet County
- Chippewa Falls (3) – Chippewa County
- Cudahy (1) – Milwaukee County
- Eagle River (1) – Vilas County
- Eau Claire (5) – Eau Claire County
- Elkhorn (1) – Walworth County
- Fish Creek (1) – Door County
- Fond du Lac (1) – Fond du Lac County
- Fort Atkinson (1) – Jefferson County
- Green Bay (6) – Brown County
- Hartford (1) – Washington County
- Hayward (1) – Sawyer County
- Holmen (1) – La Crosse County
- Hudson (1) – St. Croix County
- Janesville (2) – Rock County
- Kenosha (2) – Kenosha County
- La Crosse (3) – La Crosse County
- Ladysmith (1) – R usk County
- Lake Geneva (1) – Walworth County
- Lancaster (1) – Grant County
- Madison (11) – Dane County
- Manitowoc (1) – Manitowoc County
- Marinette (1) – Marinette County
- Marshfield (2) – Wood County
- Mauston (1) – Juneau County
- Medford (1) – Taylor County
- Menomonee Falls (2) – Waukesha County
- Menomonie (1) – Dunn County
- Mequon (3) – Ozaukee County
- Merrill (1) – Lincoln County
- Milwaukee (14) – Milwaukee County
- Minocqua (1) – Oneida County
- Monona (1) – Dane County
- Monroe (1) – Green County
- Neenah (2) – Winnebago County
- Neillsville (1) – Clark County
- New Berlin (1) – Waukesha County
- New Richmond (1) – St. Croix County
- Oconto Falls (1) – Oconto County
- Onalaska (2) – La Crosse County
- Oregon (1) – Dane County
- Oshkosh (2) – Winnebago County
- Park Falls (1) – Price County
- Plymouth (2) – Sheboygan County
- Port Washington (1) – Ozaukee County
- Prairie du Chien (2) – Crawford County
- Prairie du Sac (1) – Sauk County
- Racine (1) – Racine County
- Rhinelander (1) – Oneida County
- Rice Lake (1) – Barron County
- Richland Center (1) – Richland County
- Ripon (1) – Fond Du Lac County
- River Falls (1) – Pierce County
- St. Croix Falls (1) – Polk County
- Sauk City (1) – Sauk County
- Shawano (1) – Shawano County
- Sheboygan (3) – Sheboygan County
- Sparta (2) – Monroe County
- Stevens Point (1) – Portage County
- Sturgeon Bay (1) – Door County
- Superior (2) – Douglas County
- Tomah (1) – Monroe County
- Tomahawk (1) – Lincoln County
- Two Rivers (2) – Manitowoc County
- Watertown (1) – Dodge County
- Waukesha (2) – Waukesha County
- Waupaca (1) – Waupaca County
- Waupun (1) – Dodge County
- Wausau (2) – Marathon County
- Wauwatosa (2) – Milwaukee County
- West Allis (1) – Milwaukee County
- West Bend (1) – Washington County
- West Salem (1) – La Crosse County
- Wisconsin Rapids (1) – Wood County
- Woodruff (1) – Vilas County

DIABETES SELF-MANAGEMENT EDUCATION RECORD

NAME: _____ DATE: _____/_____/_____

Diabetes Type (check): ☐Type 1 ☐Type 2 ☐Pre-diabetes ☐Preconception ☐Pregnancy ☐Gestational

INITIAL VISIT (Date):	**CHANGES IN READINESS/BARRIERS** (Date, Initials, Comments)			
☐ Yes ☐ No Demonstrates ability to understand. ☐ Yes ☐ No Asking questions. ☐ Yes ☐ No Indicates need for clarification. Instructions Given to: _____ ☐ Individual Education ☐ Group Education ☐ Class				

BARRIERS TO SELF-CARE/LEARNING/LIMITATIONS:			**CHANGES IN READINESS/BARRIERS** (Date, Initials, Comments)			
☐ None Identified	☐ Hearing	☐ Physical				
☐ Cultural/Religious	☐ Psychosocial	☐ Speech				
☐ Emotional	☐ Literacy	☐ Visual				
☐ Lack of desire to learn	☐ Cognitive	☐ Financial				

LEARNING NEEDS: (Document those that apply on the lines below.)

Teaching Activity Key (TAK)		**Pre-program Assessment/Post-program Outcome Codes**
I = Instructed	AV = Audiovisual	+ Yes, verbalizes understanding or performs skill
R = Review/Reinstruct	D = Demonstrated	- No, unable to verbalize/perform skill
H = Handout		* See comments/note

Topic/Outcome	Pre-Program Assessment	Teaching Activity Key (code/initial/dates)				Post-Program Outcomes	Comments
Verbalizes/demonstrates	code/initial/date	Initial	Reinforce	Reinforce	Reinforce	code/initial/date	
A. Disease Process and Overview							
Definition, types, diagnostic criteria							
Causes, risk factors, symptoms							
Self-management education/MNT/DSME							
Treatment options and need for control							
Importance of diabetes control, ongoing education, and possible treatment changes							
B. Psychosocial							
Effect of stress on blood glucose							
Healthy coping strategies							
Community resources and support systems							
Depression risk screening							
C. Nutrition *							
Effect of timing, amt, and type of carb on BG							
Effect of modest wt loss (if overweight or obese) on control							
Strategies for weight management							
Understanding of personalized meal plan							
Nutrition strategies for lipid, bp mgmt							
Understanding of nutrition labels in meal planning							
Effects of alcohol on BG (hypoglycemia)							
Understanding of healthy food prep (cooking methods, recipe modification)							
Healthy dining out practices							
Skills for adapting meal plan to altered meal times, travel, holidays, sick days, schedule changes, unplanned phys act							
Understanding of nutritional/herbal supplements on diabetes control							
D. Physical Activity							
Effects of physical activity on BG (general health benefits)							
Develop a physical activity plan/goals (types, frequency, duration, intensity)							
Guidelines for a safe activity (stress test, hypoglycemia prevention)							
Adjusting food and BG testing for planned or unplanned activity							

E. Medication – Insulin*/Oral Medication(s)							
Insulin (type, dose, schedule, action, preparation, injection technique, delivery devices, side effects)							
Storage of insulin and disposal of sharps							
Pattern management							
Pre-meal correction bolus; insulin:carb ratio							
Insulin adjustments/supplements (meals, activity, changes, travel, surgery)							
Basic pump information							
Oral medication(s) (name, dose, action, schedule, side effects)							
OTC medications							
F. Monitoring *							
Blood Glucose (purpose, testing times, care of meter/strips, correct technique, log, meter Q/A, alternative site testing, lancet disposal)							
Blood glucose targets: _____							
Factors affecting BG levels							
Action for results outside target range							
A1c (define, state goal, test schedule)							
Urine Ketone Testing (why, when, how)							
G. Acute complications * (prevent, detect, treat)							
Hypoglycemia (risk, causes, signs, symptoms, treatment, prevention)							
Hypoglycemia unawareness							
Problem solve: contact MD/diabetes team							
Glucagon (prescription); support person instructed _____							
Safe driving practices; need for medical ID use							
Hyperglycemia (risk, causes, signs, symptoms, treatment, prevention)							
Sick Day (effect of illness on BG and guidelines for sick day self-care)							
Prob. solving: contacting medical provider							
H. Chronic Complications (prevent, detect, treat)							
Risk reduction strategies (A1c < 7%, controlled BG and HTN, smoking cessation, increased activity, diet, wt/BMI reduction)							
DM-focused visits every 3-6 months							
Tests (A1c, lipids, albumin/creat ratio)							
Annual dilated eye (with drops in eyes)							
Dental visits and proper oral health care							
Annual comprehens lower extremity exam							
Teach self-foot exam, routine foot care/foot wear; S/S of problems/infection and contact MD/team							
Immunizations (flu/pneumonia)							
Skin care/hygiene							
I. Goal setting & problem solving							
Problem solving strategies							
Behavior change strategies							
Personal self-care goals (AADE 7)							
J. Preconception care/pregnancy/gestational							
Preconception counseling/care, good BG ctrl							
BG control prior to conception and during pg							
Maternal and fetal risk and complications with poor control							
Monitoring and care frequency when pg							
Gestational: treatment, BG monitoring/ goals, F/U testing postpartum, risk reduct.							

* denotes survival skills

Signature/Initial/Date	Signature/Initial/Date

DIABETES PATIENT FLOW SHEET/CHART AUDIT TOOL

Patient Name _____ ID _____ Birthdate _____/_____/_____

Type of Diabetes: ☐Type 1 ☐Type 2 ☐Gestational ☐Other Date of Dx: _____/_____/_____

SBGM: ☐Yes ☐No Treatment (check all that apply): ☐Insulin ☐Oral Medication(s) ☐Diet ☐Physical Activity

Instructions: Please indicate date of exam/test, "A" for abnormal or "N" for normal, as well as the actual results, when appropriate (e.g., lab value), "D" if done elsewhere, and "R" if referred. Additional explanations should be written in the patient's clinical notes.

General Office Visits	**date/results**	**date/results**	**date/results**	**date/results**	**date/results**	**date/results**
Review management plan *Type 1: every 3 months Type 2: every 3-6 months*						
Review physical activity *each visit*						
Weight						
Height						
BMI						
Self-Management Training						
At diagnosis, then every 6-12 months or more as needed						
Medical Nutrition Therapy						
At diagnosis, then, Type 1: age < 18, every 3-6 months; age ≥ 18, every 6-12 months or more as indicated Type 2: every 6-12 months or more as indicated						
Glycemic Control						
A1c test *every 3-6 months*						
Review A1c target goal *each visit*						
Cardiovascular Care						
Lipid Profile *Children: age > 2 yrs, after dx when in glycemic control; Adults: annually*						
Total Cholesterol						
TG						
HDL						
Non-HDL						
LDL						
Blood pressure *each visit*						
Smoking status *each visit*						
Smoking cessation referral *if indicated*						
Aspirin therapy *if indicated*						
Kidney Care						
Albumin to creatinine ratio *Type 1: begin with puberty or after 5 yrs duration, then annually Type 2: at dx, then annually*						
Protein to creatinine ratio *annually after microalbumin > 300 mg/24 hrs.*						
Serum creatinine *annually*						
ACE/ARB therapy						
Eye Care						
Dilated eye exam *Type 1: If age > 10 years, within 3-5 years of onset, then annually Type 2: At diagnosis, then annually*						
Foot Care						
Inspect bare feet and stress self-exam *each visit*						
Comprehensive lower extremity exam *annually*						
Oral Care						
Oral health screening *each visit*						
Refer to dentist *every 6 months*						
Emotional/Sexual Health Care Concerns						
List: _____						
List: _____						
Preconception/Pregnancy						
Assess contraception/discuss family planning *at diagnosis and each focused visit during childbearing yrs*						
Preconception consult *3-4 months prior to conception*						
Immunizations						
Influenza *annually*						
Pneumococcal *once; revaccination per ACIP*						